Contact Information					
Date					
Agency Name					
Agency Mailing Address					
Agency Contact Representative					
Contact Telephone Number					
Contact Fax Number					
Contact Email Address					
Current Services					
Address	Services offered	License Date	License Status		
Planned services					
Describe organizational					
structure and operations					
including management/staffing					
patterns connected to service					
design as well as key roles and					
responsibilities of staff.					
Enter the number of people					
currently supported by the					
provider					
Describe provider's history					
providing DD waiver services in					
Virginia or another state					
Indicate if funding will result in	☐ New service option				
the addition of new services or	☐ Expanded service option				
expanded services					
Enter the number of people who					
will be supported in the					
proposed program as a result of					
funding					
Enter all cities/counties where	Enter Locality	Enter Service	e		
services are provided					
Enter the additional	Enter New Locality	Enter Servic	e		
cities/counties where services					
will be provided as a result of					
Jump-Start funding					
Provide justification of need for					
new or expanded services					

Indicate the services	you are	☐ Benefits Planning					
planning to offer with	n Jump-	☐ Community Coachin	g				
Start funding.	•	Community Engager	-				
(check all that apply)		☐ Community Guide					
		☐ Electronic Home-Ba	sed Services				
		☐ Employment and Community Transportation					
		☐ Independent Living Supports					
		☐ In-Home Support Services					
		☐ Peer Mentoring					
		☐ Shared Living					
Davidana ant Dian		☐ Supported Living					
Development Plan		B			T		
Element		Description			Target date		
Include how program							
changes resulting fro							
Jump-Start funding w							
organized, implemen							
completed (i.e. seque timeline of activities)	, , , , , , , , , , , , , , , , , , ,			- ,			
Describe how the ind		costs and describe how cost effectiveness is addressed.]					
identified will benefit	t from these						
changes. Describe the relation	chin						
	-						
between the planned activities and the service needs of							
individuals identified							
Start funding.	ioi juilip-						
Funding request							
Category	Description		Rate/amount	Tot	Total		
category	Description.	<u> </u>	nate/amount	100	u:		
Chahamanh of Coatain							
Statement of Sustain		1					
·		nd service provision for					
		of Jump-Start funding					
(provide relevant pro		details as an					
attachment to this ap	oplication).						
Signatures							
Provider agrees to participate in a DBHDS program review upon request: \square Yes \square No							
Provider agrees to share program accomplishments upon request for two years from approval date: \Box Yes \Box No							
This application is su		consideration by:					
Aganay's Names	bmitted for o	-					
Agency's Name:	bmitted for c						
	bmitted for d						
Print name /Title		gnature	 Date sign	ned			
			Date sign	ned			
Print name /Title Received by:	Się	gnature					
Print name /Title Received by: DBHDS representativ	Sig	gnature	 Date sig	ned/received			
Print name /Title Received by: DBHDS representativ Submit the complete	Signed application	gnature	Date sig	ned/received ent & Assignmer	nt of Award forms		